Chapel & Keller Dentistry Partnership

www.chapelandkeller.com
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Medical History

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Indicate which of the following conditions you have or have had.

☐ Acid Reflux	☐ Allergies/Hayfever	☐ Allergy-Latex	☐ Allergy-Penicillin
☐ Alzheimer's	☐ Anemia	☐ Angina	☐ Arthritis
☐ Artificial Joints	☐ ArtificialHeartValve	☐ Asthma	☐ Bactrum
☐ Bisphosphonates	☐ Blood Disease	☐ Blood Thinners	☐ Bone Density
☐ Cancer	☐ Cerebral palsy	☐ Currently Pregnant/ Nursing	☐ Diabetes
☐ Dizziness	☐ Emphysema	☐ Epilepsy	☐ Excessive Bleeding
☐ Fainting/Seizures	☐ Fibromyalgia	☐ Glaucoma	☐ HIV
☐ Heart Attack	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ High Blood Pressure	☐ High Cholesterol	☐ Jaundice	☐ Joint Replacement
☐ Kidney Disease	☐ Leukemia	☐ Liver Disease	☐ Low Blood Pressure
☐ Mental Disorders	☐ Mitral ValveProlapse	☐ Nervous Disorders	☐ Osteoporosis
☐ Other	☐ Pacemaker	☐ Radiation Treatment	☐ Recent Weight Loss
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatoid Arthritis	☐ Sinus Problems
☐ Sleep Apnea	☐ Stomach Problems	☐ Stroke	☐ Thyroid Concerns
☐ Tobacco Use	☐ Tuberculosis	☐ Ulcers	☐ Venereal Disease

If needed, please explain/clarify any conditions or alerts selected above:

_____

_____

Do you take any medications? * ◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

Do you have any allergies that are not listed above? * ◯ Yes ◯ No

Allergies not listed:

_____

_____

Please list all surgeries you have had including the year it was done:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ◯ Yes ◯ No

What antibiotic do you require to premedicate?

Name of your Physician and Phone Number: *

Preferred Pharmacy and Phone Number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY

Please review and update the following information if needed. Thank you.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) **Best time to call:** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Response Date: _____